



The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Allied Mental Health and Human Services Professions
Marriage and Family Therapy Licensure
239 Causeway Street
Boston, MA 02114

Requirements for Licensure as a Marriage and Family Therapist

The following items must be included for a complete application:

- ☐ **Completed notarized application w/ photo**
- ☐ **Check/Money Order for \$102, payable to the “Commonwealth of Mass.”
(Personal checks okay)**
- ☐ **Official Transcript(s) (Non-Baccalaureate degrees only)**
- ☐ **Are you a current Clinical Member of the American Association of Marriage and Family Therapy (AAMFT)?** If so, a copy of a certificate is required as verification.

ADDITIONAL INFORMATION FOR APPLICANTS:

Applications are reviewed at Board meetings held the third Friday of each month. The Board determines your eligibility to take the exam based on your transcripts. It is recommended that you compare your transcript to the course content areas listed in the Regulations to make sure that you meet the educational requirements. Clinical members of the AAMFT are automatically approved to take the exam; however transcripts are still required as part of the application process.

Once the Board determines your eligibility to take the exam, an examination packet will be mailed to you. If you have already taken the National Exam for Marriage and Family Therapists, you will need to have your score sent to the Massachusetts Board from the Professional Examination Service (PES), 475 Riverside Drive, New York, NY 10115-0089, TEL (212) 367-4200; FAX (212) 367-4266.

Provide copies of the Clinical Experience Applications to your approved supervisor(s) to document the required hours of experience. You are not required to submit evidence of post-master's experience with your initial application. Clinical experience will only be reviewed when it is determined that you have met all educational requirements and passed the examination. Clinical Experience forms are not required for applicants who are clinical members in good standing of the AAMFT.

Should you have any questions regarding the application process, please contact Jodi Rubin, Board Administrator, at (617) 727-3063 or via email <jodi.b.rubin@state.ma.us>

DEADLINES

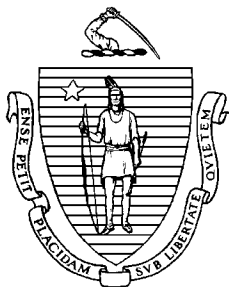
If you will be taking the National Marital and Family Therapy Examination in Massachusetts, please refer to the deadlines below for each testing window:

Testing Window	Registration Deadline
September 15 – October 11, 2003	July 15, 2003
January 19 – February 14, 2004	November 15, 2003
May 17 – June 12, 2004	February 15, 2004
September 13-October 9, 2004	July 10, 2004

Applications and official transcripts must be received by this office no later than the registration deadline. Please do not wait until the last minute, as we cannot be responsible for mail delays.

Once the Board determines your eligibility to take the exam, you will receive a letter along with an exam registration package that you will be required to submit to the Professional Exam Service (PES). Upon receipt of this form, PES will mail you a diskette that you will be able to take into any Sylvan or Prometric Testing Center in the United States at any time during the specified testing windows. Examination results are mailed approximately 4-6 weeks after the closing of each testing window.

Should you have any further questions, please contact Jodi Rubin, Board Administrator, at (617) 727-3063 or via email <jodi.b.rubin@state.ma.us>



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Please attach recent passport type

2 X 2

head and shoulder photograph

**MARRIAGE AND FAMILY THERAPIST
LICENSURE APPLICATION
NON-REFUNDABLE APPLICATION FEE: \$102**

1. Name: _____
Last First Middle Maiden

2. Address: _____
No. Street Apt. No.

City/Town State Zip Code

3. Date of Birth: _____

4. Telephone No: Day _____ Evening _____

5. Email: _____

6. USA Social Security Number (Mandatory) _____ - _____ - _____

Pursuant to G.L. c. 47A, the Division of Professional Regulation is required to obtain your security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax laws of the Commonwealth.

If you have held or currently hold a license in another jurisdiction, please complete the information below.						
State	License Number	Issue Date	Current	Lapsed	Present Status	
					Revoked/ Suspended	Probation
A letter of standing from each state listed must accompany this application.						

DISCIPLINARY HISTORY

If you answer “Yes” to any of the following questions, please attach a full explanation.

- A. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes ___ No ___
- B. Are you the subject of pending disciplinary action by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes ___ No ___
- C. Have you voluntarily surrendered or resigned a professional license to a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes ___ No ___
- D. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction? Yes ___ No ___
- E. Have you ever been convicted of a felony or misdemeanor in the United States or any country or foreign jurisdiction, other than a traffic violation for which a fine of less than \$200 was assessed? Yes ___ No ___

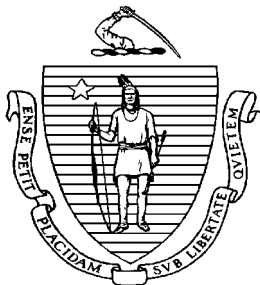
AAMFT MEMBERSHIP STATUS

Do you have current clinical membership with the American Association of Marriage and Family Therapy (AAMFT)? Yes ___ No ___

If you answered “Yes,” please include a copy of your current certification to this application

EDUCATION

College or University	Degree	Year	Major	Credits
A. Masters				
B. Post-Master’s Credits (non-CAGS)				
C. CAGS				
D. Doctoral Degree				
Official transcripts must be provided from all graduate institutions. Do not submit undergraduate transcripts.				



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CLINICAL EXPERIENCE APPLICATION

INSTRUCTIONS: Please duplicate this form as necessary. See reverse side for the definition of Approved Supervisor. PLEASE PRINT CLEARLY OR TYPE.

Name of Applicant: _____

Remainder of Form to be completed by Approved Supervisor

Name of Supervisor: _____

Address: _____

City: _____ State: _____ Zip: _____

Supervisor's Title: _____

Name/Address of Clinical Facility: _____

Nature of Facility: _____ Setting of Facility _____

Dates of Supervision of the Applicant—From: _____ To: _____

Number of Supervision Hours—Individual: _____ Group: _____

Total Number of Supervised Hours During This Period: _____

Description of Applicant's Duties:

Please include an explanation if any disciplinary action has been taken against you within the last ten years by any of the following:

Professional Association or Organization:

Yes: _____ No: _____

Governmental Authority (e.g. Professional Licensing Board):

Yes: _____ No: _____

Third Party Insurance Carrier:

Yes: _____ No: _____

Credentialing Board:

Yes: _____ No: _____

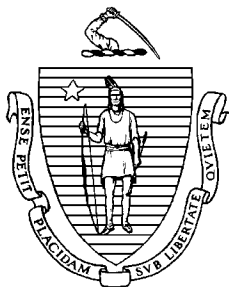
I have read the definitions of Approved Supervisor listed in 262 CMR and/or on the reverse side of this page and believe that I qualify as an approved supervisor. The undersigned states that under the pains and penalties of perjury, that the above statements are true and correct.

Signature of Approved Supervisor

Date

DEFINITION OF APPROVED SUPERVISOR (262 CMR)

- A) A marriage and family therapist designated as an approved supervisor by the AAMFT to supervise the clinical practice of marriage and family therapists; or
- B) A licensed marriage and family therapist, or mental health practitioner who meets the qualifications for licensure as a marriage and family therapist by the Board, who
 - i) has had primary supervisory responsibility for two practicing marriage and family therapists for a period of two years or the equivalent; or
 - ii) holds either a teaching or supervisory position in a recognized educational institute, institute or agency which trains marriage and family therapists, provided clinical services to individuals, couples, and families on a regular basis, or offers graduate degrees in marriage and family therapy or a related field.



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ACADEMIC PROGRAM DIRECTOR FORM

(To be filled out by Academic Director of program in Marriage and Family Therapy)

Name of Applicant _____

Name of Program Director _____

Institution _____

Department _____

Title of Program _____

An applicant for licensure as a Marriage and Family Therapist must have completed a program of graduate study meeting the requirements outlined in 262 CMR 3.01. Please indicate with a check mark whether the graduate study the applicant completed at your institution met these requirements.

YES NO

_____ _____ The program in Marriage and Family Therapy is offered in an accredited institution of higher education.

_____ _____ The program has an identified Marriage and Family Therapy faculty.

_____ _____ The program includes supervised practice and/or internships consistent with the requirements in 262 CMR 3.02(2).

_____ _____ The field based supervisor of the supervised internship meet the requirements of Approved Supervisor as defined in 262 CMR 3.02(2).

AFFIDAVIT

I, the undersigned, do state under the penalties of perjury that the answers given above are correct. I agree to provide any additional information requested by the Board.

Academic Program Director's Signature

Date

**PRE-MASTER'S DEGREE EXPERIENCE –
STUDENT PRACTICUM AND INTERNSHIP**

Name of Facility: _____

Address of Facility: _____

Your Title: _____ Dates of Supervision _____

Name and Title of Supervisor: _____

Nature of Clinical Experience: _____

POST-MASTER'S DEGREE CLINICAL EXPERIENCE

Name of Facility: _____

Address of Facility: _____

Your Title: _____ Dates of Supervision _____

Name and Title of Supervisor: _____

Nature of Clinical Experience: _____

Pursuant to G.L. c. 62C, s. 49A, I have filed all state tax returns and paid all state taxes required under law. Yes ____ No ____

Pursuant to G.L., c. 119, s. 51A and G.L. c.112, s.1A, my signature to this application is my certification that I understand my obligation to report the abuse or neglect of children.

AFFADAVIT

The applicant named on this application agrees to abide by the rules and regulations for licensing and practice of Marriage and Family Therapists (262 CMR) and attests that all statements made herein are truthful and are made under the pains and penalties of perjury.

SIGN IN THE PRESENCE OF A NOTARY PUBLIC

Applicant's Signature

Signature of Notary Public

Name of Notary Public (Print)

Date

My Commission Expires on

MARRIAGE AND FAMILY THERAPY WORK EXPERIENCE

NAME: _____

List relevant work experience in marriage and family therapy (including private practice) in chronological order (most recent experience first.)
All applicants must have 1,000 hours of clinical (direct face-to-face client contact) post-master's experience. Photocopy as necessary.

1. Name/ Address of Facility 2. Signature of Supervisor	Dates	Hours of Experience	Hours of Clinical Experience	Hours of Individual Supervision	Hours of Group Supervision
A) 1.	From:	a) Hrs/Week_____	a) Hrs/Week_____	a) Hrs/Week_____	a) Hrs/Week_____
		b) # of Weeks _____	b) # of Weeks _____	b) # of Weeks _____	b) # of Weeks _____
	2.	(a x b) _____	(a x b) _____	(a x b) _____	(a x b) _____
B) 1.	From:	a) Hrs/Week_____	a) Hrs/Week_____	a) Hrs/Week_____	a) Hrs/Week_____
		b) # of Weeks _____	b) # of Weeks _____	b) # of Weeks _____	b) # of Weeks _____
	2.	(a x b) _____	(a x b) _____	(a x b) _____	(a x b) _____
Minimum-----		3,360	1,000	100	100

Nature of experience and percentage of time in various activities:

A. _____

B. _____
